

Personality Characteristics and Development of Psychopathology in Bipolar I and Borderline Personality Disorder Patients

Somdeb Mitra · Tilottama Mukherjee

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Abstract The debate whether Bipolar Affective Disorder and Borderline Personality Disorder fall under the same spectrum or they represent separate categories has received much research attention. However, the question of their underlying psychological aetiology as well as their personality correlates has remained largely un-explored. The present study aims at gaining knowledge about and insights into these questions. The sample studied consists of 10 Bipolar I patients and 10 patients with Borderline Personality Disorder. Following a cross-sectional design, after determining the remitted phase of Bipolar I patients using Hamilton Depression Rating Scale and Young's Mania Rating Scale, the Temperament and Character Inventory, Attachment Style Questionnaire, Defense Style Questionnaire and Rorschach Inkblot Test were administered individually by the researcher. Both group of patients showed features of immaturity and instability. A correlational analysis indicated the probable pathway of development of psychopathology. The parallels of the findings to Kernberg's concept of borderline personality organization have been discussed.

Keywords Bipolar Spectrum · Psychopathology · Aetiology

Introduction

Personality represents those characteristics of the person that account for consistent pattern of feeling, thinking and behaving (Pervin and John 2001). Personality and

psychopathology influence the presentation or appearance of one another, they can share a common, underlying aetiology, and they often contribute to the development of one another (Klein et al. 1993). Many of the Axis II Personality Disorders (American Psychiatric Association 1994) may represent simply extreme and/or maladaptive variants of common personality traits, and some personality traits and personality disorders may also represent characterologic variants of Axis I mental disorder (Pervin and John 2006).

The concept of a bipolar spectrum began with Kraepelin (Paris 2009) who suggested that milder forms of mania can exist in the absence of classical symptoms, sometimes presenting only as characterological features. In the last decade, a proposal for a widened bipolar spectrum has been widely discussed (Paris 2009). The most important implication of an expansion of bipolarity would be to view other mental disorders as falling within the same spectrum and as benefitting from similar treatment. Three groups have been widely discussed in the literature: unipolar depression, adult impulsive disorders (substance abuse, bulimia, and Cluster B personality disorders), as well as childhood behavioural disorders. In the present study, the focus remains on the debate whether personality disorders with the central feature of emotional instability can be conceptualised as a variant of bipolarity and thus falling within a wider spectrum, or they form separate categories.

Both Bipolar Disorders as well as Borderline Personality Disorder (BPD) share the characteristics of mood swings, impulsive behaviour, substance misuse, suicidal risks and turbulent interpersonal relationships. Akiskal (2004) has for long argued that the emotional instability and swings from all-good to all-bad perceptual style in Borderline clients are episodes of attenuated forms of hypomania and depression due to underlying cyclothymic temperament and often require similar forms of

S. Mitra (✉)
Department of Psychology, University of Calcutta,
92 A.P.C. Road, Kolkata – 700009, Kolkata, India
e-mail: mitrasomdeb@yahoo.co.in

T. Mukherjee
Department of Psychology, University of Calcutta, Kolkata, India

pharmacological management. Affective instability and impulsiveness (also expressed by suicidal tendencies) appear to be appropriate dimensions for investigation in these disorders due to the chances of heritability, co-occurrence. Paris et al. (2007) in a literature review examined co-occurrence, phenomenology, and family prevalence, response to medication, longitudinal course, aetiology and pathogenesis. They report, the aetiology of both bipolar disorder and BPD are still poorly understood, and the data are insufficient to support any hypothesis regarding whether these two disorders fall in the same spectrum or they represent separate categories.

The literature therefore indicates the usefulness of inquiring into the personality pattern to gain an insight regarding psychopathology and related aetiological constructs (Pervin and John 2006). Personality can be studied from multiple points of view. Temperament is widely seen as the innate, heritable, biological basis of personality. The nature of attachment pattern is theorised to play a central role in personality development. Human beings tend to get rid of their conflicts and often push them into the depths of the unconscious. However, these forces remain active in the unconscious and constantly seek discharge. The overall constellation thus leads to an underlying structure of personality. The drives seeking discharge are managed by defense mechanisms. Therefore, the study of defenses can provide important insights about the conflicts and overall maturation of personality (Hall et al. 2007). All these underlying factors as well as conscious learning processes, direct experiences lead to the final character pattern. Hence, a comprehensive study of personality would require an enquiry into all these important variables that encompass the arena of conscious awareness and beyond.

Temperament (Cloninger et al. 1994) refers to automatic emotional responses to experience that are moderately heritable and stable throughout life. Character (Cloninger et al. 1994) refers to self concepts and individual differences in goals and values, which influence voluntary choices, intentions, and the meaning of what is experienced in life. Differences in character are moderately influenced by influenced by socio-cultural learning and mature in progressive steps throughout life.

Attachment may be defined as “an affectional tie that one person or animal forms between himself and another specific one—a tie that finds them together in space and endures overtime” (Arkar et al. 2005). Bartholomew (Ainsworth et al. 1978) developed a four category model of attachment styles based on the four combinations obtained by dichotomizing the participants abstract image of the self into positive (low dependence) or negative (high dependence) on one axis, and dichotomizing the

participant’s abstract image of the other into positive (low avoidance) or negative (high avoidance) on an orthogonal axis. This yielded the four attachment categories denoted by secure (positive self, positive other), preoccupied with relationships (negative self, positive other), dismissing of intimacy or dismissing avoidant (positive self, negative other), and afraid of intimacy or fearful avoidant (negative self, negative other). Research indicates (Bartholomew and Horowitz 1991; Feeney 1994) secure attachment style can work as a buffer for strains in life. By contrast, an insecure attachment might count as a predisposal to psychopathological symptoms (Kobak and Sceery 1988).

The dynamics of personality consists of the way in which psychic energy is distributed and used by the id, ego, and superego. Under the pressure of excessive anxiety, the ego is sometimes forced to operate unconsciously and take extreme measures to relieve this pressure by denying distorting or falsifying reality. (Hall et al. 2007) These measures are called defense mechanisms. Although defences operate at the unconscious level, conscious derivatives of defense mechanisms can be assessed by self report measures (Nakash-Eisikovits et al. 2002). Moreover, projective techniques can provide important insights into the unconscious aspects of personality.

Aims and Objectives of the Present Study

The present study aims to investigate the personality of individuals with Bipolar I Disorder and Borderline Personality Disorder from the perspectives of temperament, character, attachment pattern, defense styles and underlying unconscious personality structure. This is done with the aims of understanding the psychopathology of the two disorders and their similarities as well as differences. It should be noted that in the present study ICD 10 Criteria given by WHO 2010 are followed. Therefore, the categories of Mania with as well as without psychotic features are accepted as Bipolar I, and Emotionally Unstable Personality Disorder inclusive of Impulsive and Borderline type are accepted as Borderline Personality Disorder as they share the cardinal feature of impulsivity and emotional instability. Literature (Paris et al. 2007) suggests that Bipolar I and Borderline Personality Disorder fall in the extreme ends of the spectrum. Therefore, the differences would be most obvious if these two disorders when compared. Moreover, if they are indeed part of a wider spectrum, certain similarities which are the defining features of the spectrum are also likely to emerge. Finally, as it is difficult to diagnose and distinguish in a short span between Bipolar II and Borderline cases, therefore to avoid overlap Bipolar I cases are considered in the present study.

Materials and Methods

Tools Used The tools used (II–VII) for the purpose of the present study are all standardized questionnaires/tests which are widely used in clinical and research purposes. The names and purpose of use of each test is mentioned below.

- I. A Personal Information Schedule: To collect socio-demographic details
- II. Young's Mania Rating Scale (YMRS) (Bond et al. 1983): To assess and rule out mania
- III. Hamilton Depression Rating Scale (HDRS) (Andrews et al. 1993): To assess and rule out Depression
- IV. Temperament and Character Inventory (TCI) (Cloninger et al. 1994): To assess the Temperament and Character patterns.
- V. Attachment Style Questionnaire (ASQ) (Rorschach 1921): To assess the nature of attachment pattern.
- VI. Defense Style Questionnaire (DSQ) (Priyamvada et al. 2009): To assess the nature of defensive manoeuvres.
- VII. Rorschach Inkblot Test (RIT) (Klopfer et al. 1954; Young et al. 1978): To assess the underlying unconscious personality structure.

Procedure

The present study was conducted for partial fulfilment of the requirements of M. Phil in Clinical Psychology and was approved by the ethical board of Department of Psychology, University of Calcutta. It is a cross sectional study involving 10 Bipolar I patients (6 male and 4 female) and 10 Borderline Personality Disorder patients (5 male and 5 female). The patients were selected on the basis of the following criteria:

Inclusion Criteria

- Age—18–60 years.
- Diagnosis of either Bipolar Affective Disorder or Emotionally Unstable Personality Disorder according to the diagnostic criteria of ICD 10, WHO, 2010.
- Adult individuals residing in Kolkata and its suburbs.
- Adult individuals with education up to class VIII (at least).
- Adult individuals willing to take part in the study.

Exclusion Criteria

- Individuals suffering from significant physical illness.
- Individuals with personal history suggestive of other psychiatric co morbidities except either Bipolar Affective Disorder or Borderline Personality Disorder.
- Individuals with history suggestive of organic involvement.
- Individuals with any physical handicap.
- Individuals who was either not willing or not in a position to answer all the questions of the questionnaire, as well as complete the examination on Rorschach Inkblot Test.

Translation of Questionnaires A Bengali version of TCI translated for research purpose and used earlier was taken as many patients would have difficulty in English. A Bengali translation of the ASQ and DSQ was prepared by taking the help of experts (individuals having knowledge of both languages, having at least post-graduate level of education) and back-translation was utilized in the process.

Collection of Data The patients were interviewed individually by the investigator in the chambers used for clinical purposes within the Department of Psychology. Data was collected separately from each individual patient. First, the nature of the study was explained individually to the potential subjects. They were assured about confidentiality and after conclusion of the study, the investigator would personally inform them about the results of their data. Thus, written consent was obtained from each individual prior to administration of the questionnaire. Prior to administration of the scales, the researcher confirmed the diagnoses by talking a short history and assessed the Bipolar Affective Disorder Patients on YMRS, and both the patient groups on HDRS. Thus, it was at first established that the patients were in remission, and in a position to participate in the study.

Then, the investigator read out the items clearly and the subjects gave their responses verbally which the investigator noted down. To avoid fatigue, the TCI and ASQ were administered on the first day, and the DSQ and RIT were administered on a separate day. The time gap was kept within a week between the two sessions, and the YMRS and HDRS were administered to assess their emotional stability on the second session too, prior to administration of the tools. In this way, data from 10 patients with Bipolar Affective Disorder (6 male, 4 females) and 10 subjects with a diagnosis of Emotionally Unstable Personality Disorder (5 male and 5 female) were collected.

Scoring The responses were scored according to the procedure described in the manuals of the respective scales and scores on TCI, ASQ, DSQ as well as RIT were obtained.

Statistical Analysis For the analysis of data, initially the Mean and Standard Deviations (S.D.) for each of the variables of all the questionnaires were computed for the two groups (each having $n=10$) individually. The obtained data have been analyzed by using non-parametric tests. The analysis have been done in order to find out whether there exists considerable similarities/differences in the personality profiles of patients with Bipolar Affective Disorder and Emotionally Unstable Personality Disorder. As the results indicated no significant differences between the two groups, therefore they were clubbed together. Thereafter, Spearman's Rho was calculated as a method of non-parametric statistic to find out the significant correlations between the separate variables being

studied. SPSS 10 for Windows was used for the statistical analyses.

Results

Colour shock was identified in the group of bipolar affective disorder—a difference of 11.34 s whereas the BPD group had a difference of only 0.54 s. On average both Bipolar and BPD groups gave around 3 popular responses (3.3 and 3.1 respectively). The responses based on small detail, those mentioning colour, animal movement, or anatomy etc. were very few and did not come out as significant in any of the statistical analyses. Therefore those have been omitted for the sake of brevity Table 1.

Mann–Whitney ‘U’ Test on all the variables, between the Groups of Bipolar I and Emotionally Unstable Personality Disorder Patients reveal that none of the differences within the means were statistically significant at 0.05 levels. Therefore the null hypothesis is accepted, which means that there exists no significant difference between the Bipolar I and Emotionally Unstable Personality Disorder groups on the variables selected in the present study. This further indicates that the two groups can be thought of as coming from the same population, with regards to the variables studied Table 2.

The above table indicates that, Novelty seeking is inversely related to Self Directedness. Harm Avoidance is inversely related to, Persistence, but is positively related to preoccupied attachment style as well as neurotic defense style. Persistence is positively related to Confidence in attachment but inversely related to Preoccupied attachment style. Self directedness is inversely related to preoccupied attachment style. High persistence is associated with high whole response, human responses, and confidence in attachment but negatively related to neurotic defense and preoccupied attachment style. Self directedness is inversely related to immature defense, preoccupied attachment style and large usual detail responses in RIT. Cooperativeness is inversely related with space responses in RIT. Higher number of usual detail responses is associated with attachment styles marked by high preoccupation with relationship as well as relationships secondary to achievement. High inanimate movement with little emphasis on form is negatively correlated with neurotic defences. Animal detail responses is inversely associated with low neurotic defense, discomfort with closeness. High RT on chromatic cards is inversely related to neurotic defense. High neurotic defence is associated with preoccupation with relationships whereas high immature defenses associated with relations as secondary to achievement.

Discussion

Although Allport (Hamilton 1960) suggests that personality is unique, but in attempt to arrive at quantification of variables which can aid in scientific theorizing and prediction, the patients of Bipolar I and Borderline Personality Disorder according to ICD-10 criteria, were grouped on the basis of their respective diagnosis. The researcher is aware that such grouping together can lead to loss of information unique to each case, but such a method of Idiographic research is beyond the scope of the present study. The mean values of each of the relevant variables were taken as representative of the group. Furthermore, to reduce the complexities of analysis and interpretation, as well as keeping in mind the small sample size ($n=10$ in each of the two groups), several subscales were not analyzed individually; rather the composite score available by summing up the subscales were considered. While calculating the correlations, the degree of relationship across different tests was considered. In TCI the scores on temperament and character were taken separately as they differ significantly from the theoretical perspective; correlations within different measures on other tests have been ignored due to space constraints.

The personality profile of the Bipolar I patients indicate that, overall their temperaments are within average, and they have inherent capacity to experience the four basic emotions of Fear (Harm Avoidance), Anger (Novelty Seeking), Love (Reward Dependence), and Tenacity (Persistence) within the average range. On average, low scores on the character scales indicate that these individuals are likely to be dominated by reactions to stimulation and pressure from external circumstances, rather than their personal goals and values; are inconsiderate of other's feelings, cannot tolerate ambiguity and have difficulty accepting suffering with equanimity. Sayin et al. (Allport's 1937) also reported that the Bipolar patients did not differ from the normal controls on the different temperament scales of TCI, the main differences were in character dimensions, namely, self-directedness and cooperativeness. The attachment styles of the Bipolar I patients reveal a dismissing attachment style to be most prominent, (Discomfort with Closeness on ASQ) as they have a positive view self, but negative view of others. Neeren et al. (Sayin et al. 2007) suggests that bipolar group reported less warmth/acceptance and greater psychological control for both parents than did the control group. Thus, these individuals would have difficulty in emotionally relating to others and try to compensate by being self-sufficient. Klein (Neeren et al. 2006) noted that that these patients have difficulty in the ‘depressive position’ and perceive the caregiver negatively. To avoid the pain of the depressive position, these individuals resort to the primitive manic defense. Hence, they try to hold on to a grandiose view of self, beneath which the impoverished self concept which seeks care is hidden. These patients are most likely to use

Table 1 Means and SDs on the different subscales of TCI, ASQ, DSQ and the major variables of RIT

Variable	Bipolar I		BPD	
	Mean	SD	Mean	SD
Novelty Seeking (NS)(TCI)	18.4	5.46	22.8	5.65
Harm Avoidance (HA)(TCI)	15.3	4.92	16.1	5.91
Reward Dependence (RD)(TCI)	13.9	2.96	15.1	3.41
Persistence (P)(TCI)	5.4	1.58	5.3	1.57
Self Directedness (SD)(TCI)	26.7	7.01	23.7	7.69
Cooperativeness (CO)(TCI)	27.8	6.46	24.7	7.01
Self Transcendence (ST)(TCI)	15.9	7.81	14.5	5.28
Confidence(ASQ)	30.6	6.88	34	6.41
Preoccupation with relationships(ASQ)	32.5	7.98	36.9	4.53
Relations as secondary (to achvmt)(ASQ)	25.7	5.56	24.2	5.67
Discomfort with closeness(ASQ)	41.1	8.70	37.9	6.85
Need for approval(ASQ)	25.9	6.35	26.3	4.74
Mature (DSQ)	31.30	11.95	31.4	8.02
Neurotic(DSQ)	41.80	11.48	50.09	14.49
Immature(DSQ)	119.6	21.41	116.2	25.25
Whole (W)(RIT)	5.9	1.79	6.3	2.45
Large usual detail (D) (RIT)	4.9	4.36	2.9	1.97
Space (S) (RIT)	0.3	0.28	0.9	0.97
Form based response (F) (RIT)	10	4.47	5.9	2.64
Human movement (M) (RIT)	1.2	1.55	1	0.82
Inanimate movement (m)	4.1	0.32	0.4	0.32
Animal (A) (RIT)	5.6	3.13	4	2.05
Human (H) (RIT)	1.9	1.52	1.3	1.06
Form Level average or above (RIT)	10.3	4.85	9.4	2.59

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neurotic defenses (DSQ) such as pseudo-altruism, reaction formation, and undoing, followed by tendencies to use more immature defenses. They rarely are able to use mature defenses such as humour. In accordance with the conceptualization of Kernberg (Segal 1975) they were found to be utilizing splitting as their most utilized mechanism of defense. The RIT profile of the Bipolar I patients indicate the presence of reality orientation but poor level of ego development indicating impulsivity, lack of inner stability and empathy. The archaic impulses represent such a threat to the ego that they are not acknowledged. These patients have a stereotyped view of the world—that is too narrow range of interests, probably resulting from disturbed adjustment and they lack recognition of everyday problems and facts. Due to a fear of being repulsed, there is over-cautiousness in emotional contacts.

They are disturbed by the emotional impact from the environment. They seem to have an over-riding need for intellectual accomplishment which is likely to be a defense mechanism of compensatory sort.

The temperament and character profiles of Borderline Personality Disorder shares striking similarity to that of Bipolar Affective Disorder patients (which has already been discussed above). However, on average they had a high score on the Temperament of Novelty Seeking. Thus, these patients seem to have a biological vulnerability to have excessive Anger making them quick tempered and impulsive. On all the other temperament and character scales of TCI they displayed similar features as the Bipolar I group. Cloninger et al. (1994) also mentioned in the TCI manual itself that Borderline clients are likely to have higher Novelty

Table 2 Variables with significant correlations

Variable	Positive relationship		Negative relationship	
	+0.05	+0.01	−0.05	−0.01
Novelty seeking (TCI)			Self Directedness	
Harm avoidance (TCI)	Neurotic defense, Preoccupation with relationships			Persistence
Persistence (TCI)	Whole response in RIT Human Response RIT		Neurotic defense, Preoccupation with relationships	
	Confidence in Attachment			
Self directedness (TCI)			Immature Defense, Preoccupation with relationships	Large usual detail (D) (RIT)
Cooperativeness (TCI)			Space response in RIT	
Whole (RIT)			Neurotic defense, Preoccupation with relationships	
Large usual detail (RIT)		Preoccupation with relationships, Relationships as secondary (to achievement) (ASQ)		
Inanimate movement (RIT)				Neurotic Defense
Animal detail (RIT)			Neurotic Defense Discomfort with closeness(ASQ)	
R T on chromatic cards (RIT)			Neurotic Defense	
Neurotic Defense	Preoccupation with relationships(ASQ)			
Immature Defense	Relationships as secondary (to achievement) (ASQ)			

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Seeking. Kernberg (Kernberg 2004) also mentions the probability of borderlines constitutionally having a surplus of aggression. These patients scored highest on ‘Preoccupied’ dimension (on ASQ), which reveal that although they have a positive view of others, but their view of self is negative, which makes them anxious regarding their relationships. Linehan (Kernberg 1994) conceptualized BPD as resulting from a failure of an emotionally vulnerable child to develop a balanced relationship with its invalidating environment and thereafter suffer from chronic mood dysregulation. This concept is similar to the failure of development of attachment bond, also mentioned by Kernberg (Segal 1975). The

defensive patterns of BPD patients are similar to Bipolar I patients and they are also most likely to use neurotic defenses namely the defenses of undoing and pseudo-altruism. They are also likely to immature defenses such somatisation and acting-out. Although they use mature defenses less, they try to ‘anticipate’ the future to ward of anxiety. RIT profile of the BPD patients indicates striking similarities to that of the Bipolar I patients discussed earlier. However they seem to get less disturbed by emotional impact from the environment compared to Bipolar I group.

Therefore, on the whole, both groups of patients display poor capacity for emotion regulation and stress tolerance, lack

of empathy, insecure attachment, and immaturity in character pattern. They fail to integrate their conscious moral values with their inner primitive emotional needs resulting in poor 'intra' as well as 'inter' personal adjustment.

There was no statistically significant difference for any of the variables, the two groups can be thought of as belonging to the same spectrum, in the context of the variables chosen in the study. This finding is in line with a large section of literature on this area, from different points. Akiskal (Akiskal 2004) holds that the recurrent nature of affective disorder, coupled with familial bipolarity and spontaneous and pharmacologic excursions into brief periods of elation, places the affective pathology of borderline patients in the soft bipolar realm (that can be broadly defined as bipolar II). Kernberg's (Kernberg 2004) conceptualization includes patients diagnosed as Cyclothymic and Hypomanic which is obviously linked with affective temperament and disorders. Kernberg's conceptualization has also received support from Akiskal (Akiskal 2004).

As there exists no statistically significant differences between the two groups, they were combined together to find out the correlations between the variables of the current study.

Results indicate that temperamentally, individuals who were more persistent showed more ability to utilization of intellectual and emotional resources of the personality (high number of W and H responses in RIT). They also were able to develop a more trusting attachment bond (Confidence on ASQ). They were unlikely to be preoccupied with their relationships (ASQ) or use neurotic defenses (DSQ). Thus, those who were able to tolerate frustrations, showed less anxiety and more maturity in their character pattern.

Individuals who were more self-confident in character and showed ability to guide themselves were less likely to use immature defenses such as projection, acting out, splitting, isolation etc. (Indicated by DSQ). As mentioned earlier, they had low aggressiveness (Novelty seeking on TCI) in their temperament and hence less likely to be overwhelmed by aggressive impulses leading to acting out. They were less likely to be preoccupied with their relationships (ASQ). They were unlikely to use an everyday, common sense approach to utilize their intelligence—which indicates features of insecurity (D responses in RIT)—and rather be more creative in approach.

People who are temperamentally prone to anxiety (High Harm Avoidance on TCI), are likely to be more preoccupied by their fear of losing the object of attachment and feel insecure (Preoccupied attachment indicated by ASQ) and they go on to use defenses such as undoing, pseudo-altruism, idealization and reaction formation (Neurotic Defenses of DSQ). Thus, they are likely to repress the threatening aspect of the intra-psychic conflict and act on the more socially desirable aspects and cling on to their

relationships. As they are afraid to explore the world outside the attachment figures, they lack the ability to develop skills of leadership and decision making in their character as indicated by low self directedness (TCI). On the other hand, those who were temperamentally prone to aggression (High Novelty seeking on TCI) also were likely to lack self-directedness. Thus, in line with Cloninger et al. (Paris et al. 2007) it can be said that clients with innate surplus aggression, or fearfulness, would show more immaturity in character pattern.

Individuals who gave more responses in the RIT based on the obvious aspects of the blots were more likely to be preoccupied with relationships (ASQ). This finding is congruent with the interpretation mentioned by Klopfer et al., (Young et al. 1978) i.e., these individuals tend to be anxious and insecure, therefore, fail to utilize their potential to achieve overall development of the personality by integrating their experiences. Some persons with these features of attachment insecurity are also likely to view their relationships as secondary to achievement (ASQ). Thus, unlike those who are remain preoccupied with their relationships, some may become more defensive due to their insecurities and deny the attachment need. They thus become more concerned about their accomplishments in materialistic terms. This hypothesis is further supported by the finding that, those who are more likely to see relationships as secondary to achievement (ASQ) are likely to use immature defenses. This marks their characterologic immaturity and tendency to deny reality or take account of it. On the other hand, those with pre-occupied pattern are more likely to use neurotic defenses as mentioned earlier.

Individuals who were aware about the threat to their personality organization (m responses in RIT), were unlikely to use neurotic defenses centering around repression. Color Shock (RIT), i.e., difficulty in organization of emotion with intellect in creative process, was also found to be inversely related to utilization of neurotic defense. Thus, individuals who are more disturbed, are vaguely aware of their primitive impulses, show immature character pattern and either deny or act-out impulses were unlikely to utilize repression as a defense due to presence of unresolved infantile impulses. Therefore, when presented with emotionally charged material, their personalities become vulnerable to emotional withdrawal or affective explosion.

Those who showed characterological features of high cooperativeness, i.e., ability to understand and empathise with people, showed less paranoid tendencies indicated by space responses in RIT and vice versa.

The above discussion indicates three different clusters of personality characteristics. One category that has high persistence tends to go on and develop mature character patterns. The second group tend to have innate vulnerabilities to anxiety and utilize defenses centering on repression and

successfully keep the negative affects and impulses outside the conscious awareness, but fail to properly utilize their emotional resources and remain anxious about their relationships. The third group, have more severe pathology and fail to use repression as a defense, their primitive impulses threaten their personality organization, they also have more primitive defensive patterns and deny their attachment bonds and seek materialistic success as a compensatory mechanism. These clusters are similar to the conceptualization of Kernberg (Segal 1975) which states the existence of different personality organizations—the neurotic, borderline and psychotic personality organizations. He stated that different patients from a single phenomenological diagnosis can have different personality organizations, and the opposite to this also holds true. These features also share striking similarities to Horney's (Linehan 1993) conceptualization of moving towards people and moving against people. Those showing prominent features of anxiety, by being preoccupied are moving towards relationship by repressing their basic anxiety. However, those with even lesser maturation of personality tend to deny their attachment need and seek achievement as a source of power and thus express their hostility on the attachment bond. This leads to more severe constriction of the personality and the primitive defenses are less likely to ward off the impulses successfully—resulting in an underlying threat to the ego organization resulting in suspiciousness.

From the perspective of developmental psychopathology, it can be inferred that some children are born with an emotional over-sensitivity, i.e., surplus of anger and fear, lack in tenacity, or may have other genetic vulnerabilities (predisposing temperament). Due to their emotional sensitivity, they are likely to be frustrated easily. Moreover, such individuals come from families with invalidating environment (Horney 1950) or families with lack of warmth and more over-protectiveness (Harned et al. 2006). From such an environment these individuals are likely to develop insecure attachment with their caregivers. The working models which develop due to insensitive care-giving are not likely to be congenial for the development of the child (Alloy et al. 2006). These working models help not only with interactions with the caregiver, but also generalize to new situations and people (Bowlby 1975). Based on the nature of vulnerability in the child as well as the degree of invalidation received, the child develops defensive manoeuvres of relating to people and tackle the basic anxieties (Linehan 1993). This in turn shapes his characterological deficits—i.e. inability to function appropriately and independently by gaining control over impulses. Thus there remains the ambivalence regarding whether to seek relationship or stay away from them—neither of which they can do properly. This leads to an increased risk for emotional dysregulation (Kernberg 1994) leading to engaging in a

number of aggressive, impulsive, and risk-taking behaviours to alleviate emotional distress. Thus, when faced with stressful situations, the borderline clients might engage in deliberate self harm, whereas the bipolar patients may disrupt their regular routine and develop full-blown episodes of mania or depression.

In conclusion, it can be stated that although both groups have considerable similarities in their personality profiles, the results should be interpreted with caution due to the small sample size. Moreover, the study being a cross sectional one with a small group with considerable heterogeneity, can only lead to development of preliminary assumptions regarding classification and aetiology. Although no quantitative differences were found, qualitative differences indicate BPD have higher novelty seeking (TCI), they have preoccupied attachment style (ASQ). Whereas the Bipolar I group had Discomfort with Closeness (ASQ), lower reality orientation compared to the other group and colour shock in RIT. These differences indicate lower level of personality integration in Bipolar I clients. Although these differences can be explained by Kernberg (Kernberg 2004) as well as Akiskal (Priyamvada et al. 2009) further detailed large scale and longitudinal studies are necessary to check the validities of preliminary hypotheses regarding aetiology as well as resolve the debate about BPD falling in Bipolar spectrum.

However, the current paper helps to gain an understanding of the personality profiles of Bipolar I and Borderline Personality Disorder patients and indicate how personality plays an important mediating role in the manifestation of psychopathology as well as in determining remission. This study thus indicates the prognostic factors which can also guide the therapist to decide the client's suitability for a specific mode of therapy. Thus, psychological therapies which address the areas of affect regulation, and interpersonal relationship are likely to be of prime importance in management and relapse prevention of both Borderline as well as Bipolar I patients.

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